

KNEE QUESTIONNAIRE

Today's Date _____

Age: _____ Weight: _____ lbs.

Height: _____ feet _____ inches

Sex:

- Male
- Female

Attach patient information sticker in this space

Approximate Date of Initial Injury: _____

Treatment:

Have you ever had surgery on your knee? **Yes** **No**

If YES, what type of surgery or surgeries? _____

What was the date of your surgery or surgeries? _____

Have you ever had surgery on your **OTHER** knee? **Yes** **No**

If YES, what type of surgery? _____

What was the date of your surgery or surgeries? _____

Side of Knee Problem:

- Right
- Left
- Both: Right side more than Left
- Both: Left side more than Right

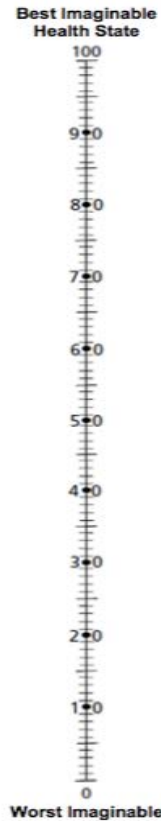
Your own
health state
today

Smoking:

Do you currently smoke? yes no

Did you ever smoke? yes no

For how many years did you smoke? _____ NA



EQ-VAS: We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your health state is today

COMORBIDITY QUESTIONNAIRE: The following is a list of common health problems. Please indicate in the first column whether you have this problem. If you do have the problem, indicate in the second column if you have received treatment for it and whether or not it limits your activities in the third column.

Problem	Do you have the problem?		Do you receive treatment for it?		Does it limit your activities?	
	No	Yes	No	Yes	No	Yes
Heart Disease	No	Yes	No	Yes	No	Yes
High Blood Pressure	No	Yes	No	Yes	No	Yes
Lung Disease	No	Yes	No	Yes	No	Yes
Diabetes	No	Yes	No	Yes	No	Yes
Ulcer or Stomach Disease	No	Yes	No	Yes	No	Yes
Kidney Disease	No	Yes	No	Yes	No	Yes
Liver Disease	No	Yes	No	Yes	No	Yes
Anemia or other Blood Disease	No	Yes	No	Yes	No	Yes
Cancer	No	Yes	No	Yes	No	Yes
Depression	No	Yes	No	Yes	No	Yes
Pain and Swelling in Joints	No	Yes	No	Yes	No	Yes
Low Back pain	No	Yes	No	Yes	No	Yes
Osteoporosis	No	Yes	No	Yes	No	Yes
Fractures	No	Yes	No	Yes	No	Yes
Other:						

UCLA Activity Score: Please circle the number that best describes your activity level over the last 6 months. **Circle only one response.**

regularly = once per week or more, sometimes = once per month or less

10	I regularly participate in impact sports such as jogging, tennis, skiing, acrobatics, ballet, heavy labor, or backpacking
9	I sometimes participate in in impact sports such as jogging, tennis, skiing, acrobatics, ballet, heavy labor, or backpacking
8	I regularly participate in very active events such as golf or bowling
7	I regularly participate in active events such as bicycling
6	I regularly participate in moderate activities such as swimming and unlimited housework or shopping
5	I sometimes participate in moderate activities such as swimming and unlimited housework or shopping
4	I regularly participate in mild activities such as walking, limited housework and limited shopping
3	I sometimes participate in mild activities such as walking, limited housework and limited shopping
2	I am mostly inactive: restricted to minimal activities of daily living
1	I am wholly inactive: dependent upon others; cannot leave residence

PAST KNEE HISTORY

Have you had any previous knee problems? Yes No If yes, which knee? Left Right Both

If YES, what was the injury? _____

Did any knee injury require surgery? Yes No If yes, which knee? Left Right Both

If YES, what procedure and when? _____

PLEASE RATE THE FOLLOWING BY FILLING IN THE CIRCLE OF YOUR CHOICE.

SYMPTOMS: DO YOU EXPERIENCE ANY OF THE FOLLOWING?

- 1. Pain Never ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Always
- 2. Swelling Never ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Always
- 3. Giving Way Never ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Always
- 4. Stiffness Never ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Always
- 5. Popping Never ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Always
- 6. Clicking Never ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Always
- 7. Catching Never ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Always
- 8. Locking Never ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Always
- 9. Night pain (*Does your pain wake you up at night?*) Never ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Always
- 10. Pain with prolonged sitting (*Pain relieved after standing up.*) Never ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Always

ACTIVITY: DO YOU HAVE PROBLEMS WITH THE FOLLOWING?

- 1. Walking No Problem ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Unable
- 2. Any Type of Squats No Problem ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Unable
- 3. Going UP Stairs No Problem ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Unable
- 4. Going DOWN Stairs No Problem ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Unable
- 5. Running No Problem ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Unable
- 6. Cutting No Problem ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Unable
- 7. Jumping No Problem ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Unable
- 8. Twisting No Problem ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Unable

FUNCTION:

- 1. Are you able to walk on level ground? No Problem ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Unable
- 2. Are you able to walk on rough ground, inclines, or negotiate curves? No Problem ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Unable
- 3. Do you have problems running? No Problem ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Unable
- 4. Do you have problems cutting while running or jogging? No Problem ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Unable
- 5. Do you have problems jumping? No Problem ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Unable
- 6. Do you have problems participating in competitive sports? No Problem ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Unable

DO YOU PLAY SPORTS? Yes No What Sport? _____ Position: _____

WHAT LEVEL OF SPORT? High School College Other _____

FUNCTION

Based on your previous level of function, what % of normal is your current level of function = _____%

PAIN LEVEL: Please mark the line or circle a number to represent your pain level.

What is your pain level right now?

0 1 2 3 4 5 6 7 8 9 10

What is your typical or average pain?

0 1 2 3 4 5 6 7 8 9 10

What is your pain level at its best?

0 1 2 3 4 5 6 7 8 9 10

What is your pain level at its worst?

0 1 2 3 4 5 6 7 8 9 10

No pain at all ←—————→ Pain as bad as it can be

THE PITTSBURGH SLEEP QUALITY INDEX

The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. Please answer all the questions.

1. During the past month, when have you usually gone to bed at night?
usual bed time _____
2. During the past month, how long (in minutes) has it usually taken you to fall asleep each night?
number of minutes _____
3. During the past month, at what time have you normally woken up in the morning?
usual getting up time _____
4. During the past month, how many hours of *actual* sleep did you get at night? (This may be different from the number of hours you spend in bed).
hours of sleep per night _____

For each of the remaining questions, check the ONE best response. Please answer all questions.

5. During the past month, how often have you had trouble sleeping because you ...

(a) Cannot get to sleep within 30 minutes

- Not during the past month
- less than once/week
- once or twice/week
- 3 or more times/week

(b) Wake up in the middle of the night or early morning

- Not during the past month
- less than once/week
- once or twice/week
- 3 or more times/week

(c) Have to get up to use the bathroom

- Not during the past month
- less than once/week
- once or twice/week
- 3 or more times/week

(d) Cannot breathe comfortably

- Not during the past month
- less than once/week
- once or twice/week
- 3 or more times/week

(e) Cough or snore loudly

- Not during the past month
- less than once/week
- once or twice/week
- 3 or more times/week

(f) Feel too cold

- Not during the past month
- less than once/week
- once or twice/week
- 3 or more times/week

(g) Feel too hot

- Not during the past month
- less than once/week
- once or twice/week
- 3 or more times/week

(h) Had bad dreams

- Not during the past month
- less than once/week
- once or twice/week
- 3 or more times/week

(i) Have pain

- Not during the past month
- less than once/week
- once or twice/week
- 3 or more times/week

(j) Other reason(s), please describe _____
How often during the past month have you had trouble sleeping because of this?

- Not during the past month
- less than once/week
- once or twice/week
- 3 or more times/week

6. During the past month, how would you rate your sleep quality overall?

- Very good
- Fairly good
- Fairly bad
- Very bad

7. During the past month, how often have you taken medicine (prescribed or “over the counter”) to help you sleep?

- Not during the past month
- less than once/week
- once or twice/week
- 3 or more times/week

8. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?

- Not during the past month
- less than once/week
- once or twice/week
- 3 or more times/week

9. During the past month, how much of a problem has it been for you to keep up enough enthusiasm to get things done?

- No problem at all
- Only a very slight problem
- Somewhat of a problem
- A very big problem

SYMPTOMS

These questions should be answered thinking of your knee symptoms during the **last week**.

S1. Do you have swelling in your knee?

Never Rarely Sometimes Often Always

S2. Do you feel grinding, hear clicking or any other type of noise when your knee moves?

Never Rarely Sometimes Often Always

S3. Does your knee catch or hang when moving?

Never Rarely Sometimes Often Always

S4. Can you straighten your knee fully?

Never Rarely Sometimes Often Always

S5. Can you bend your knee fully?

Never Rarely Sometimes Often Always

Stiffness

The following questions concern the amount of joint stiffness you have experience during the **last week** in your knee.

Stiffness is a sensation of restriction or slowness in the ease with which you move your knee joint.

S6. How severe is your knee joint stiffness after first wakening in the morning?

Never Rarely Sometimes Often Always

S7. How severe is your knee stiffness after sitting, lying or resting **later in the day**?

Never Rarely Sometimes Often Always

Pain

P1. How often do you experience knee pain?

What amount of knee pain have you experience the **last week** during the following activities?

P2. Twisting/pivoting on your knee

None Mild Moderate Severe Extreme

P3. Straightening knee fully

None Mild Moderate Severe Extreme

P4. Bending knee fully

None Mild Moderate Severe Extreme

P5. Walking on flat surface

None Mild Moderate Severe Extreme

P6. Going up or down stairs

None Mild Moderate Severe Extreme

For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your knee.

P7. At night while in bed

None Mild Moderate Severe Extreme

P8. Sitting or lying

None Mild Moderate Severe Extreme

P9. Standing upright

None Mild Moderate Severe Extreme

Function, daily living

The following questions concern your physical function. By this, we mean your ability to move around and to look after yourself. For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your knee.

A1. Descending stairs

None Mild Moderate Severe Extreme

A2. Ascending stairs

None Mild Moderate Severe Extreme

A3. Rising from sitting

None Mild Moderate Severe Extreme

A4. Standing

None Mild Moderate Severe Extreme

A5. Bending to floor/pick up an object

None Mild Moderate Severe Extreme

A6. Walking on flat surface

None Mild Moderate Severe Extreme

A7. Getting in/out of car

None Mild Moderate Severe Extreme

A8. Going shopping

None Mild Moderate Severe Extreme

A9. Putting on socks/stockings

None Mild Moderate Severe Extreme

A10. Rising from bed

None Mild Moderate Severe Extreme

A11. Taking off socks/stockings

None Mild Moderate Severe Extreme

A12. Lying in bed (turning over, maintaining knee position)

None Mild Moderate Severe Extreme

A13. Getting in/out of bath

None Mild Moderate Severe Extreme

A14. Sitting

None Mild Moderate Severe Extreme

A15. Getting on/off toilet

None Mild Moderate Severe Extreme

A16. Heavy domestic duties (moving heavy boxes, scrubbing floors, etc.)

None Mild Moderate Severe Extreme

A17. Light domestic duties (cooking, dusting, etc.)

None Mild Moderate Severe Extreme

Function, sports and recreational activities

The following questions concern your physical function when being active on a higher level. The questions should be answered thinking of what degree of difficulty you have experienced during the **last week** due to your knee.

SP1. Squatting

None Mild Moderate Severe Extreme

SP2. Running

None Mild Moderate Severe Extreme

SP3. Jumping

None Mild Moderate Severe Extreme

SP4. Twisting/pivoting on your injured knee

None Mild Moderate Severe Extreme

SP5. Kneeling

None Mild Moderate Severe Extreme

Quality of life

Q1. How often are you aware of your knee problem?

None Mild Moderate Severe Extreme

Q2. Have you modified your life style to avoid potentially damaging activities to your knee?

None Mild Moderate Severe Extreme

The questions should be answered thinking of what degree of difficulty you have experienced during the **last week** due to your knee.

Q3. How much are you troubled with lack of confidence in your knee?

None Mild Moderate Severe Extreme

Q4. In general, how much difficulty do you have with your knee?

None Mild Moderate Severe Extreme

1. Currently, how satisfied are you with the pain level of your knee while sitting?
 Very Satisfied Satisfied Neutral Dissatisfied Very Dissatisfied
2. Currently, how satisfied are you with the pain level of your knee while lying in bed?
 Very Satisfied Satisfied Neutral Dissatisfied Very Dissatisfied
3. Currently, how satisfied with your knee function while getting out of bed?
 Very Satisfied Satisfied Neutral Dissatisfied Very Dissatisfied
4. Currently, how satisfied are you with your knee function while performing light household duties?
 Very Satisfied Satisfied Neutral Dissatisfied Very Dissatisfied
5. Currently, how satisfied are you with your knee function while performing leisure recreational activities?
 Very Satisfied Satisfied Neutral Dissatisfied Very Dissatisfied

WALKING AND STANDING

1. Can you walk without any aids (such as a cane, crutches or wheelchair)?
 Yes No
2. If not, which of the following aid(s) do you use?
 wheelchair walker crutches two canes
 one crutch one cane knee sleeve/brace other _____
3. Do you use these aid(s) because of your knees?
 Yes No
4. For how long can you stand (with or without aid) before sitting due to knee discomfort?
 cannot stand 0-5 minutes 6-15 minutes 16-30 minutes
 31-60 minutes more than an hour
5. For how long can you walk (with or without aid) before stopping due to knee discomfort?
 cannot stand 0-5 minutes 6-15 minutes 16-30 minutes
 31-60 minutes more than an hour

STANDARD ACTIVITIES

How much does your knee bother you during each of the following activities?	No bother	Slight	Moderate	Severe	Very Severe	cannot do (because of knee)
	5	4	3	2	1	0
1. Walking on an uneven surface	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Turning or pivoting on your leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Climbing up or down a flight of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Getting up from a low couch or a chair without arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Getting into or out of a car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Moving laterally (stepping to the side)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ADVANCED ACTIVITIES

1. Climbing a ladder or step stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Carrying a shopping bag for a block	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Squatting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SF-12 General Health

INSTRUCTIONS: For each of the following questions, please **circle** only one number on each line.

1. In general, would you say your health is:

Excellent	Very good	Good	Fair	Poor
1	2	3	4	5

2. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

		Yes, limited a lot	Yes, limited a little	No, not limited at all
a.	Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf	1	2	3
b.	Climbing <u>several</u> flights of stairs	1	2	3

3. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

		All of the time	Most of the time	Some of the time	A little of the time	None of the time
a.	Accomplished <u>less</u> than you would like	1	2	3	4	5
b.	Were limited in the <u>kind</u> of work or other activities	1	2	3	4	5

4. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

		All of the time	Most of the time	Some of the time	A little of the time	None of the time
a.	Accomplished <u>less</u> than you would like	1	2	3	4	5
b.	Did work or other activities <u>less carefully than usual</u>	1	2	3	4	5

5. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

Not at all	A little bit	Moderately	Quite a bit	Extremely
1	2	3	4	5

6. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...

		All of the time	Most of the time	Some of the time	A little of the time	None of the time
a.	Have you felt calm and peaceful?	1	2	3	4	5
b.	Did you have a lot of energy?	1	2	3	4	5
c.	Have you felt downhearted and depressed?	1	2	3	4	5

7. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
1	2	3	4	5

OXFORD KNEE SCORE QUESTIONNAIRE

The purpose of the Oxford Knee Score is to help assess the impact that your knee has had on your daily life in the past four weeks. Please answer the questions below on your experience over the past 4 weeks.

1. How would you describe the pain you usually have in your knee?
 - None
 - Very Mild
 - Mild
 - Moderate
 - Severe
2. Have you had any trouble washing and drying yourself (all over) because of your knee?
 - No trouble at all
 - Very little trouble
 - Moderate trouble
 - Extreme difficulty
 - Impossible to do
3. Have you had any trouble getting in and out of the car or using public transport because of your knee? (With or Without a stick)
 - No trouble at all
 - Very little trouble
 - Moderate trouble
 - Extreme difficulty
 - Impossible to do
4. For how long are you able to walk before the pain in your knee becomes severe?
 - No pain > 60 minutes
 - 16 – 60 minutes
 - 5 – 15 minutes
 - Around the house only
 - Not at all – severe on walking
5. After a meal (sat at a table), how painful has it been for you to stand up from a chair because of your knee?
 - Not at all painful
 - Slightly painful
 - Moderately painful
 - Very painful
 - Unbearable
6. Have you been limping when walking, because of your knee?
 - Rarely / never
 - Sometimes or just at first
 - Often, not just at first
 - Most of the time
 - All of the time

7. Could you kneel down and get up again afterwards?
- Yes, easily
 - With little difficulty
 - With moderate difficulty
 - With extreme difficulty
 - No, impossible
8. Are you troubled by pain in your knee at night in bed?
- Not at all
 - Only one or two nights
 - Some nights
 - Most nights
 - Every night
9. How much has pain from your knee interfered with your usual work?
- Not at all
 - A little bit
 - Moderately
 - Greatly
 - Totally
10. Have you felt that your knee might suddenly give away or let you down?
- Rarely/never
 - Sometimes or just at first
 - Often, not at first
 - Most of the time
 - All the time
11. Could you do household shopping on your own?
- Yes, easily
 - With little difficulty
 - With moderate difficulty
 - With extreme difficulty
 - No, impossible

Tick the box beside the reply that is closest to how you have been feeling in the past week.
 Don't take too long over your replies: your immediate is best.

D	A		D	A	
		I feel tense or 'wound up':			I feel as if I am slowed down:
	3	Most of the time	3		Nearly all the time
	2	A lot of the time	2		Very often
	1	From time to time, occasionally	1		Sometimes
	0	Not at all	0		Not at all
		I still enjoy the things I used to enjoy:			I get a sort of frightened feeling like 'butterflies' in the stomach:
0		Definitely as much	0		Not at all
1		Not quite so much	1		Occasionally
2		Only a little	2		Quite Often
3		Hardly at all	3		Very Often
		I get a sort of frightened feeling as if something awful is about to happen:			I have lost interest in my appearance:
3		Very definitely and quite badly	3		Definitely
2		Yes, but not too badly	2		I don't take as much care as I should
1		A little, but it doesn't worry me	1		I may not take quite as much care
0		Not at all	0		I take just as much care as ever
		I can laugh and see the funny side of things:			I feel restless as I have to be on the move:
0		As much as I always could	3		Very much indeed
1		Not quite so much now	2		Quite a lot
2		Definitely not so much now	1		Not very much
3		Not at all	0		Not at all
		Worrying thoughts go through my mind:			I look forward with enjoyment to things:
3		A great deal of the time	0		As much as I ever did
2		A lot of the time	1		Rather less than I used to
1		From time to time, but not too often	2		Definitely less than I used to
0		Only occasionally	3		Hardly at all
		I feel cheerful:			I get sudden feelings of panic:
3		Not at all	3		Very often indeed
2		Not often	2		Quite often
1		Sometimes	1		Not very often
0		Most of the time	0		Not at all
		I can sit at ease and feel relaxed:			I can enjoy a good book or radio or TV program:
0		Definitely	0		Often
1		Usually	1		Sometimes
2		Not Often	2		Not often
3		Not at all	3		Very seldom

Please check you have answered all the questions

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

0 – not at all 1 – to a slight degree 2 – to a moderate degree 3 – to a great degree 4 – all the time

When I'm in pain ...

- 1 I worry all the time about whether the pain will end.
- 2 I feel I can't go on.
- 3 It's terrible and I think it's never going to get any better.
- 4 It's awful and I feel that it overwhelms me.
- 5 I feel I can't stand it anymore.
- 6 I become afraid that the pain will get worse.
- 7 I keep thinking of other painful events.
- 8 I anxiously want the pain to go away.
- 9 I can't seem to keep it out of my mind.
- 10 I keep thinking about how much it hurts.
- 11 I keep thinking about how badly I want the pain to stop.
- 12 There's nothing I can do to reduce the intensity of the pain.
- 13 I wonder whether something serious may happen.

Total Knee Patients Only

What do you expect to accomplish with your knee replacement:

1. Do you expect your knee joint replacement surgery will relieve your pain?
 - No, not at all
 - Yes, a little bit
 - Yes, somewhat
 - Yes, a moderate amount
 - Yes, a lot
2. Do you expect your surgery will help you carry out your normal activities of daily living?
 - No, not at all
 - Yes, a little bit
 - Yes, somewhat
 - Yes, a moderate amount
 - Yes, a lot
3. Do you expect your surgery will help you perform leisure, recreational or sports activities?
 - No, not at all
 - Yes, a little bit
 - Yes, somewhat
 - Yes, a moderate amount
 - Yes, a lot

Sports Participation

In the last 12 months did you participate in competitive sports? ₁ Yes ₂ No

(Competitive sports defined as: **individual** sports, such as running, cycling or ice skating; **dual** sports, such as doubles tennis, and **team** sports competition, such as soccer, football, drill team, dance, or cheerleading)

Please list the sport(s) (i.e. soccer, ice skating, tennis etc.) you participated in the last 12 months and level of participation.

- _____ ₁ Elite ₂ College ₃ High School ₄ Select/Travel ₅ Junior High ₆ Other _____
- _____ ₁ Elite ₂ College ₃ High School ₄ Select/Travel ₅ Junior High ₆ Other _____
- _____ ₁ Elite ₂ College ₃ High School ₄ Select/Travel ₅ Junior High ₆ Other _____
- _____ ₁ Elite ₂ College ₃ High School ₄ Select/Travel ₅ Junior High ₆ Other _____

Post Operative Patients Only

Are you satisfied with your knee surgery?

Yes No

Please indicate how satisfied you are with your knee surgery:

Extremely Satisfied Very Satisfied Satisfied Somewhat Satisfied Unsatisfied

If you could, would you choose again to have this surgery performed on your knee?

Yes No

How would you rate your knee today as percentage of normal (on a scale from 0% to 100%) with 100% being normal?

